Prescriber Criteria Form

Cysteamine opth 2024 PA Fax 926-A v1 010124.docx
Cystaran, Cystadrops (cysteamine ophthalmic solution)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**.
Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Cysteamine opth.

Drug Name (select from list of drugs shown):

| | | |
|---|---|---|
| **Patient Name:** | | |
| **Patient ID:** | | |
| **Patient DOB:** | **Patient Phone:** | |
| **Prescriber Name:** | | |
| **Prescriber Address:** | | |
| **City:** | **State:** | **Zip:** |
| **Prescriber Phone:** | **Prescriber Fax:** | |
| **Diagnosis**: | **ICD Code(s):** | |

| **Please circle the appropriate answer for each question.** | | | |
|---|---|---|---|
| 1 | Does the patient have a diagnosis of cystinosis?<br>[If no, then no further questions.] | Yes | No |
| 2 | Was the diagnosis confirmed by ANY of the following: A) the presence of increased cystine concentration in leukocytes, B) genetic testing, C) demonstration of corneal cystine crystals by slit lamp examination?<br>[If no, then no further questions.] | Yes | No |
| 3 | Does the patient have corneal cystine crystal accumulation? | Yes | No |

| | |
|---|---|
| Comments: | _____ |

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

**Prescriber (or Authorized) Signature:** _____ **Date:**_____